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4.c. Family planning services and supplies for individuals of child bearing age.

Payment to Health Department Family Planning Clinics shall be on the basis of a negotiated fee not to exceed average cost on a facility-by-facility basis.

For other providers see specific services, e.g. physicians, hospitals.

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5. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

PHYSICIAN'S FEE SCHEDULE

(a) Effective January 1, 2000, physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere, the North Carolina Medicaid Fee Schedule shall be based on the Medicare Fee Schedule Resource Based Relative Value System (RBRVS), except for payments to the various Medical Faculty Practice Plans of the University of North Carolina - Chapel Hill and East Carolina University which shall be reimbursed at cost and cost settled at year end; but with the following clarifications and modifications:

(1) A maximum fee is established for each service and is applicable to all specialties and settings in which the service is rendered. Payment is equal to the lower of the maximum fee or the provider's customary charge to the general public for the particular service rendered.

(2) Fees for services deemed to be associated with adequacy of access to health care services may be increased based on administrative review. The service must be essential to the health needs of the Medicaid recipients, no other comparable treatment available and a fee adjustment must be necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients.

(3) Fees for new services are established based on this Rule, utilizing the most recent RBRVS, if applicable. If there is no relative value unit (RVU) available from Medicare, fees shall be established based on the fees for similar services. If there is no RVU or similar service, the fee shall be set at 75 percent of the provider's customary charge to the general public. For codes not covered by Medicare that Medicaid covers, annual changes in the Medicaid payments will be applied each January 1 and fee increases will be applied based on the forecasted Gross National Product (GNP) Implicit Price Deflator. Said annual changes in the Medicaid payments shall not exceed the percentage increase granted by the North Carolina State Legislature.

(4) For codes not covered by Medicare that Medicaid covers, a code may also be decreased, based on administrative review, if it is determined that the fee may exceed the Medicare allowable amount for similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time, and other resources required to provide the particular service.

(b) This reimbursement limitation shall become effective in accordance with the provisions of G.S. 108A-55(c). These changes to the Physician's Fee Schedule allowables shall become effective when the Health Care Financing Administration, U. S. Department of Health and Human Services, approves amendment to HCFA by the Director of the Division of Medical Assistance on or about January 1, 2000 as #MA 99-12, wherein the Director proposes amendments of the State Plan to amend the Physician's Fee Schedule.

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OTHER PRACTITIONERS FEE SCHEDULE

A maximum fee is established for each service and is applicable to all specialties and settings in which the service is rendered. Payment is equal to the lower of the maximum fee or the provider's customary charge to the general public for the particular service rendered.

(1) Fees for office services, hospital services, nursing home services, consultations, and obstetric services are derived from the standard fees that were established for all specialties effective January 1, 1988.

(2) Fees for all services are established by applying the following method to the fees in effect on May 1, 1989:

  (a) The higher of the inpatient or outpatient fee is selected for each service within each specialty and the weighted average of this amount is computed among all specialties. The average is weighted by the number of services billed by each specialty in 1988.

  (b) The weighted average fee is then increased by ten percent.

(3) Annual fee increases are applied each January 1 based on the forecast of the gross national product (GNP) implicit price deflator, but not to exceed the percentage increase approved by the North Carolina State Legislature.

(4) Fees for new services are established based on the fees for similar existing services. If there are no similar services, the fee is established at 75 percent of estimated average charge.

(5) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time, and other resources required to provide the particular service.

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Medicaid Participation Rates
For General Practice/Family Practice,
Obstetricians/Gynecologists, and Pediatricians

The rates for selected procedures provided in this plan amendment are the same for pediatricians, obstetricians/gynecologists, and general practitioners/ family practitioners. Since January 1988, North Carolina's reimbursement plan for physician's services has not provided for differences in specialty for the same procedure codes.

North Carolina's HMO premium payments take into consideration rates for obstetrical and pediatric services. When the upper limits are established for HMO premiums, we calculate what would be paid in a fee-for-service arrangement, including payment for pediatric care and obstetrical care. The estimated fee for service amount is used as the upper limit, against which the proposed HMO fee is tested.

Three of seven practicing general/family practitioners in Chowan County participate in Medicaid. However, these practitioners in Chowan provide both obstetrical and pediatric services. When the three physician specialties are combined, then six of ten participate for a ratio of 60%.

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6a-d. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law (podiatrists' services, optometrists' services, chiropractor services, and nurse practitioner services).

(1) Fees for physician services are based on the Medicaid fee schedule in effect on May 1, 1989. A maximum fee is established for each service and is applicable to all specialties and settings in which the service is rendered. Payment is equal to the lower of the maximum fee or the provider's customary charge to the general public for the particular service rendered. This plan also applies to other medical practitioners, such as chiropractors, optometrists, podiatrists, and nurse practitioners.

(2) Fees for office services, hospital services, nursing home services, consultations, and obstetric services are established at the levels specified in the fee schedule in effect on May 1, 1989. These fees are the standard fees that were established for all specialties effective January 1, 1988.

(3) Fees for all other physician services are established by applying the following method to the fees in effect on May 1, 1989:

(a) The higher of the inpatient or outpatient fee is selected for each service within each specialty and the weighted average of this amount is computed among all specialties. The average is weighted by the number of services billed by each specialty in 1988.

(b) The weighted average fee is then increased by 10 percent.

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(4) Annual fee increases are applied each January 1 based on the forecast of the gross national product (GNP) implicit price deflator, but not to exceed the percentage increase approved by the North Carolina State Legislature.

(5) Fees for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75 percent of estimated average charge.

(6) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time, and other resources required to provide the particular service.

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7. HOME HEALTH SERVICES

Services provided by Medicare certified home health agencies participating in the North Carolina Medicaid Program are to be reimbursed on a prospective payment basis as set forth in this plan. Qualified providers of Durable Medical Equipment (and DME associated supplies) and Home Infusion Therapies are paid on the basis of reasonable charges as defined in Section 7B and C, respectively. The intent of this plan is to develop reasonable rates that provide incentives for the cost effective and efficient delivery of home health services.

A. REIMBURSEMENT METHODS FOR CERTIFIED HOME HEALTH AGENCIES

(a) A maximum rate per visit is established annually for each of the following services:
- (1) Registered or Licensed Practical Nursing Visit;
- (2) Physical Therapy Visit;
- (3) Speech Therapy Visit;
- (4) Occupational Therapy visit;
- (5) Home Health Aide Visit.

(b) The maximum rates for the services identified in Section (a) above are computed and applied as follows:

(1) Payment of claims for visits is based on the lower of the billed customary charges or the maximum rate of the particular service. Governmental providers with nominal charges may bill at cost. For this purpose, a charge that is less than 50 percent of cost is considered a nominal charge. For such governmental providers, the payment amount is equal to the lower of the cost as billed or the applicable maximum rate.

(2) Maximum per visit rates effective July 1, 1996, for Registered or Licensed Practical Nursing, Physical Therapy, Speech Therapy, and Occupational Therapy shall be equal to the rates in effect on July 1, 1995.

(i) To compute the annual maximum rates effective each July 1 subsequent to July 1, 1996, the maximum rates per visit are adjusted as described in Sections (4), (5), and (6).

(3) Maximum per visit rate effective July 1, 1996 for Home Health Aide shall be equal to the rate in effect on July 1, 1995.

(i) To compute the annual maximum rates effective each July 1 subsequent to July 1, 1996, the fiftieth percentile cost per visit calculated from the base year 1994 cost reports is adjusted as described in Sections (4), (5), and (6).

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(4) Each year maximum rates are adjusted by an annual cost index factor. The cost index has a labor component with a relative weight of 75 percent and a non-labor component with a relative weight of 25 percent. The relative weights are derived from the Medicare Home Health Agency Input Price Index published in the Federal Register dated May 30, 1986. Labor cost changes are measured by the annual percentage change in the average hourly earnings of North Carolina service wages per worker. Non-labor cost changes are measured by the annual percentage change in the GNP Implicit Price deflator.

(5) The annual cost index equals the sum of the products of multiplying the forecasted labor cost percentage change by 75 percent and multiplying the forecasted non-labor cost percentage change by 25 percent. For services included under Section 2 the July 1, 1996 effective rates are multiplied by the cost index factor for each subsequent year up to the year in which the rates apply. For services included under Section 3 (i) base year costs per visit are multiplied by the cost index factor for each subsequent year up to the year in which rates apply.

(6) Other adjustments may be necessary for home health services to comply with federal or state laws or rules.

(c) Medical supplies except those related to provision and use of Durable Medical Equipment are reimbursed at the lower of a provider's billed customary charges or a maximum amount determined for each supply item. Fees will be established based on average, reasonable charges if a Medicare allowable amount cannot be obtained for a particular supply item. Estimates of reasonable cost will be used if a Medicare allowable amount cannot be obtained for a particular supply or equipment item. The Medicare allowable amounts will be those amounts available to the Division of Medical Assistance as of July 1 of each year.

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APPEALS

Providers may appeal maximum rates by presenting written requests and supporting data. Rates will not be adjusted retroactively. Appeals will be processed in accordance with Division procedures for Provider Reimbursement Reviews.

COST REPORTING AND AUDITING

Annual cost reporting is required in accordance with the Medicare principles of reimbursement.

PAYMENT ASSURANCES

(a) The State will pay the amounts determined under this plan for each covered service furnished in accordance with the requirements of the State Medicaid Plan, provider participation agreement, and Medicaid policies and procedures. The payments made under this methodology will not exceed the upper limits as established by 42 C.F.R. 447.325.

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(b) Participation in the program is limited to providers who accept, as payment in full, the amounts paid in accordance with this plan.

(c) In all circumstances involving third party payment, Medicaid is the payor of last resort. Any amounts paid by non-Medicaid sources are deducted in determining Medicaid payment. For patients with both Medicare and Medicaid coverage, Medicaid payment is limited to the amount of Medicare-related deductibles and/or coinsurance for services, supplies and equipment covered under the Medicare program.

(d) Excess payments may be recouped from any provider found to be billing amounts in excess of its customary charges, or costs if charges are nominal.

B. Durable Medical Equipment

Eff. 8/1/91 (a) Payment for each claim for durable medical equipment and associated supplies shall be equal to the lower of the supplier's usual and customary billed charges or the maximum fee established for each item of durable medical equipment or related supply. The maximum fees are set at the Medicaid fee schedule in effect on July 1, 1991. Fees for added equipment shall be at Medicare Part B Fees. If a Medicare fee can not be obtained for added equipment, then the fee shall be based on an estimate of reasonable cost. The maximum allowable fee shall be updated each August 1 based on the Gross National Product (GNP) implicit price deflator, but not to exceed the percent increase approved by the North Carolina State Legislature. [The maximum allowable fee may be adjusted for any changes resulting from market and cost analysis conducted by the Division of Medical Assistance.] There shall be no retroactive payment adjustments for fee changes.

(b) Each equipment item shall be assigned to one of the following categories of payment methods:

(1) Purchase fee paid for inexpensive, routinely purchased, and customized equipment, and DME Supplies.